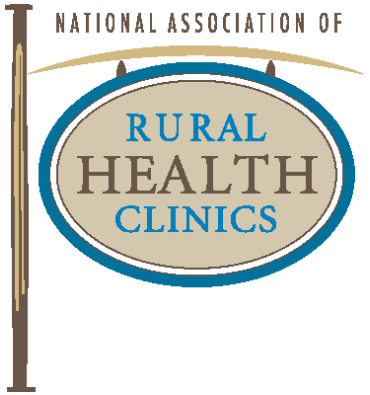

Legislative Update

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Discussion Around Idaho RHC Association

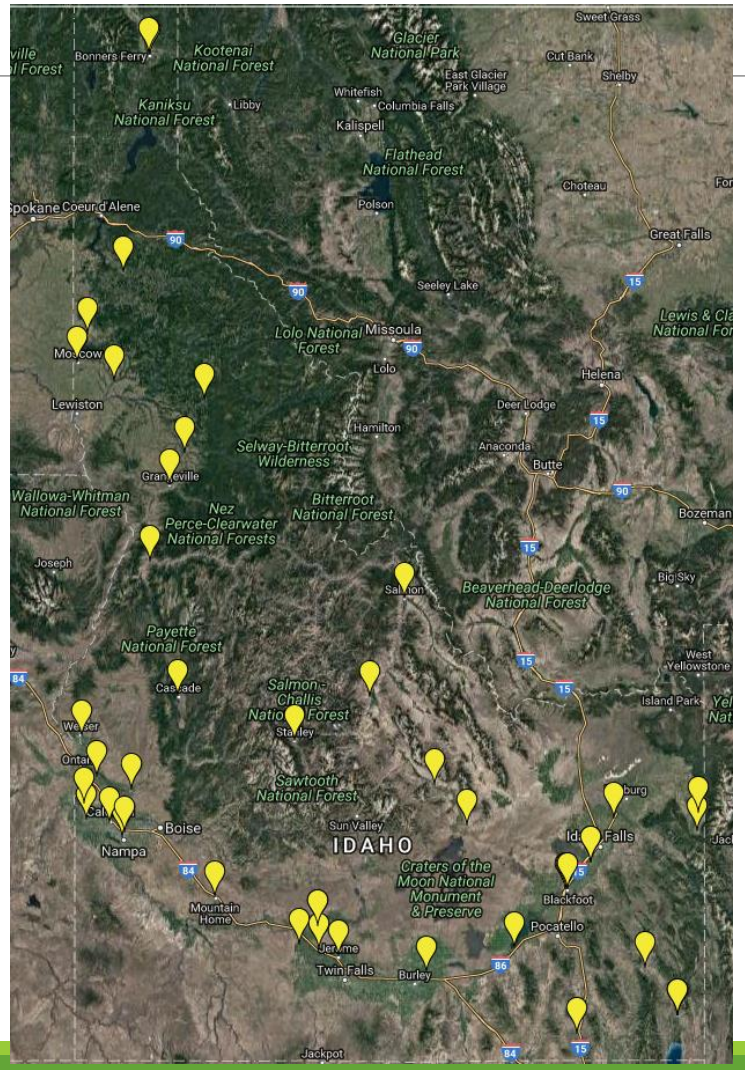
- Most pressing question: Is there a state issue that is of critical importance to RHCs?
- Is there a desire to have Idaho RHC conferences? What would those entail?
- Will the number of RHCs in Idaho support an effective association or should RHCs seek to play larger roles in larger groups?

EXAMPLES:

- CARHC, Medi-Cal (Medicaid) stopped paying for dental services for adults, but the CARHC was able to take Medi-Cal to court and get that benefit back. (State-focused Advocacy)
- MARHC (Missouri) was able to get RHC providers to be eligible distant site providers for Medicaid. (State-focused Advocacy)
- TARHC (Texas) has a state-wide list serve so that folks can discuss state specific questions. (education)

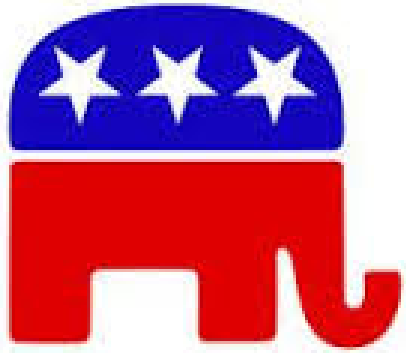
What we will cover

- 2016 Election
- 2017 Physician Fee Schedule Final Rule
  - Chronic Care Management changes
  - Diabetes Prevention Program
- MACRA Final Rule
- RHC national legislative issues
  - Raising the RHC cap
  - Site Neutral payments



2016 Election

- Repeal of ACA
- Selling Insurance Across State Lines
- MACRA Implementation
- Site Neutral Payment Policies
- Block Grants to States for Medicaid



Restoring Americans' Healthcare Freedom Reconciliation Act of 2015

HealthCare.gov

- If you want a preview of what an ACA repeal via reconciliation would look like this is it.
  - Eliminates Risk Corridor Program
  - Repeals subsidy individuals on healthcare.gov receive after 2 years
  - Repeals the individual mandate by dropping the penalty for not having health insurance to $0
  - Repeals employer mandate to provide insurance
  - Eliminates all federal support to states for Medicaid expansion (would be phased in)
  - Repeals Cadillac tax and medical device tax

RHC Medicaid Payment

- From Donald Trump's first 100 days plan:
  - Repeal and Replace Obamacare Act. Fully repeals Obamacare and replaces it with Health Savings Accounts, the ability to purchase health insurance across state lines, **and lets states manage Medicaid funds**. Reforms will also include cutting the red tape at the FDA: there are over 4,000 drugs awaiting approval, and we especially want to speed the approval of life-saving medications.

- Statutory language
  - Section 1902 (bb) of the Social Security Act mandates that "the State plan shall provide for payment for such services in an amount (calculated on a per visit basis) that is equal to 100 percent of the average of the costs of the center or clinic of furnishing such services."
  - 2001 costs adjusted for inflation

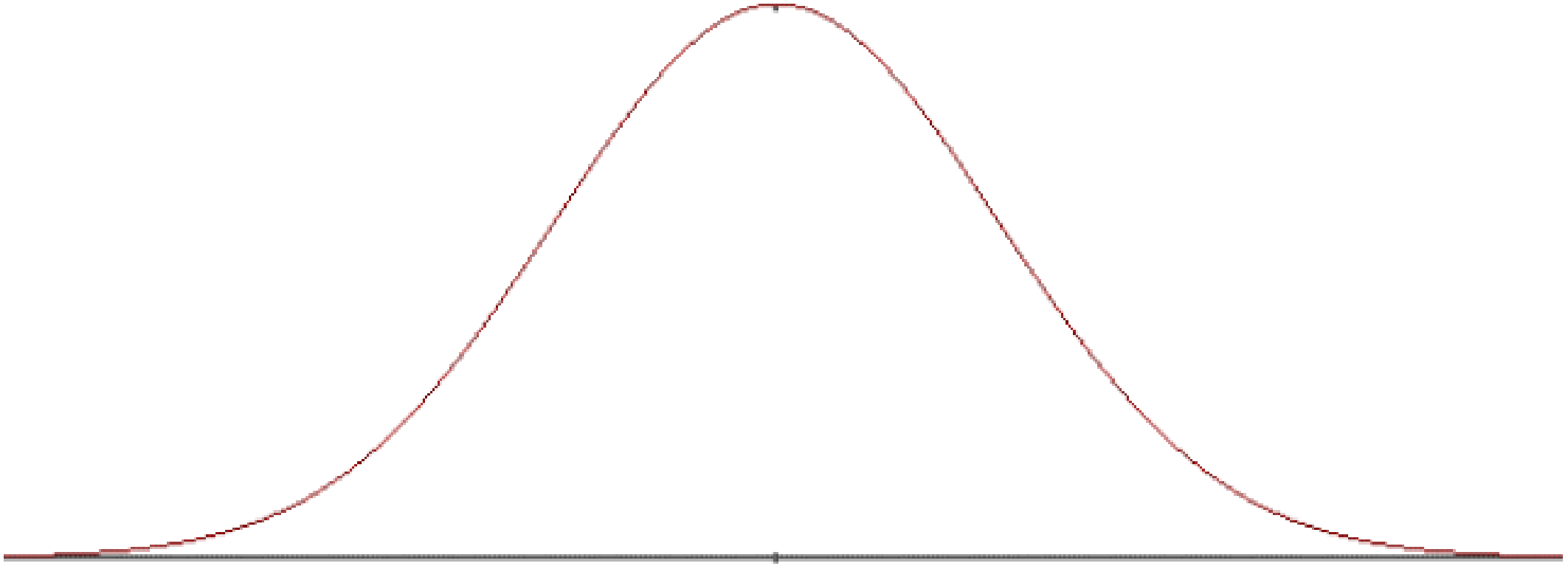
2017 Physician Fee Schedule - CCM

- CMS has finalized a change the supervision requirement from Direct Supervision to General Supervision for CCM Services
- Will allow RHC to more easily contract with 3rd Party vendors
- CCM represents both an opportunity to improve outcomes and increase revenue in your RHC
- Begins on Jan. 1 2017

MACRA – Does it Apply to RHCs?

- MACRA (Medicare Access and CHIP Re-authorization Act) does it affect RHCs?
  - Mostly no
- We anticipate that most RHCs will not be affected by MACRA
  - MIPS includes a low volume exception – RHCs should qualify
  - APMs vs “Advanced APM models” for the purposes of MACRA
- Could it affect RHCs in the future?
  - Quality is coming to the RHC program but it is unclear how

MIPS (Merit Based Incentive Payment System) – What is that?



Composite Performance Score Categories

Category	Year 1 – 2017 Reporting, 2019 Reimbursement	Year 2 – 2018 Reporting, 2020 Reimbursement	Year 3 - 2019 Reporting, 2021 Reimbursement
Quality	60%	45%	30%
Clinical Performance Improvement Activities	15%	15%	15%
Advancing Care Initiative Practices	25%	25%	25%
Resource Use	0	15%	30%

MIPS RHC Voluntary Reporting

- CMS is allowing RHCs to voluntarily report
  - Will have no bearing on RHC AIR
  - May allow RHCs to test waters and transition to traditional office
  - NARHC is warning CMS not to generalize the scores that are reported
  - Unclear if all the moving parts of the MIPS CPS would translate well to RHC billing on the UB-04
- Low-volume exception finalized as:
  - Less than $30,000 of Part B charges **OR** provides care to fewer than 100 Part B-enrolled Medicare beneficiaries
  - If you don't qualify for an exception…MIPS adjustments will only apply to those claims submitted on the 1500.

Pick your Pace

Option 1: “test the quality payment program”

- Submit some data and avoid a negative payment adjustment

Option 2: Participate for part of the calendar year

- Smaller positive/negative adjustment

Option 3 Participate for full calendar year

- As initially designed, would be eligible for full 4% adjustment up or down

Option 4 Participate in Advanced APM

APMs – What are They?

- Harder to generalize because there are many different kinds of APMs
  - To be an Advanced APM one must:
    - Require participants to use certified EHR technology
    - Provide payment for services based on the quality measures comparable to those used in MIPS
    - Bear more than nominal amount of risk for monetary losses
- APMs vs. “Advanced APMs” for purposes of MACRA
  - Providers must be participating in Advanced APMs in order to avoid MIPS/receive the formal incentive payments in the MACRA law
- Important to note that one of the main incentives to join an advanced APMs involves a lump sum payment of 5% to providers. However, RHC services (because they are not reimbursed under the PFS) would not be included in the amount upon which the APM incentive payment is based.

How to Qualify for incentive payments in APM? Option 4

Year	2019	2020	2021	2022	2023	2024
Percent of revenue through advanced APM entity	25%	25%	50%	50%	75%	75%

APMs, advanced APMs and RHCs

- To be clear, RHC's CAN participate in APMs and advanced APMs
- Any RHC joining an APM would do so not because of some formal government incentive payment, but rather because the APM itself offers value to the RHC
- Still very early on in the development of advanced APMs
- Only Advanced APMs proposed are:
  - Comprehensive ESRD Care (CEC) (LDO Arrangement)
  - Comprehensive Primary Care Plus [in a model/testing phase…RHCs excluded from participating]
  - Medicare Shared Savings Program Track 2 and 3
  - Next Generation ACO Model
  - Oncology Care Model two-sided risk arrangements

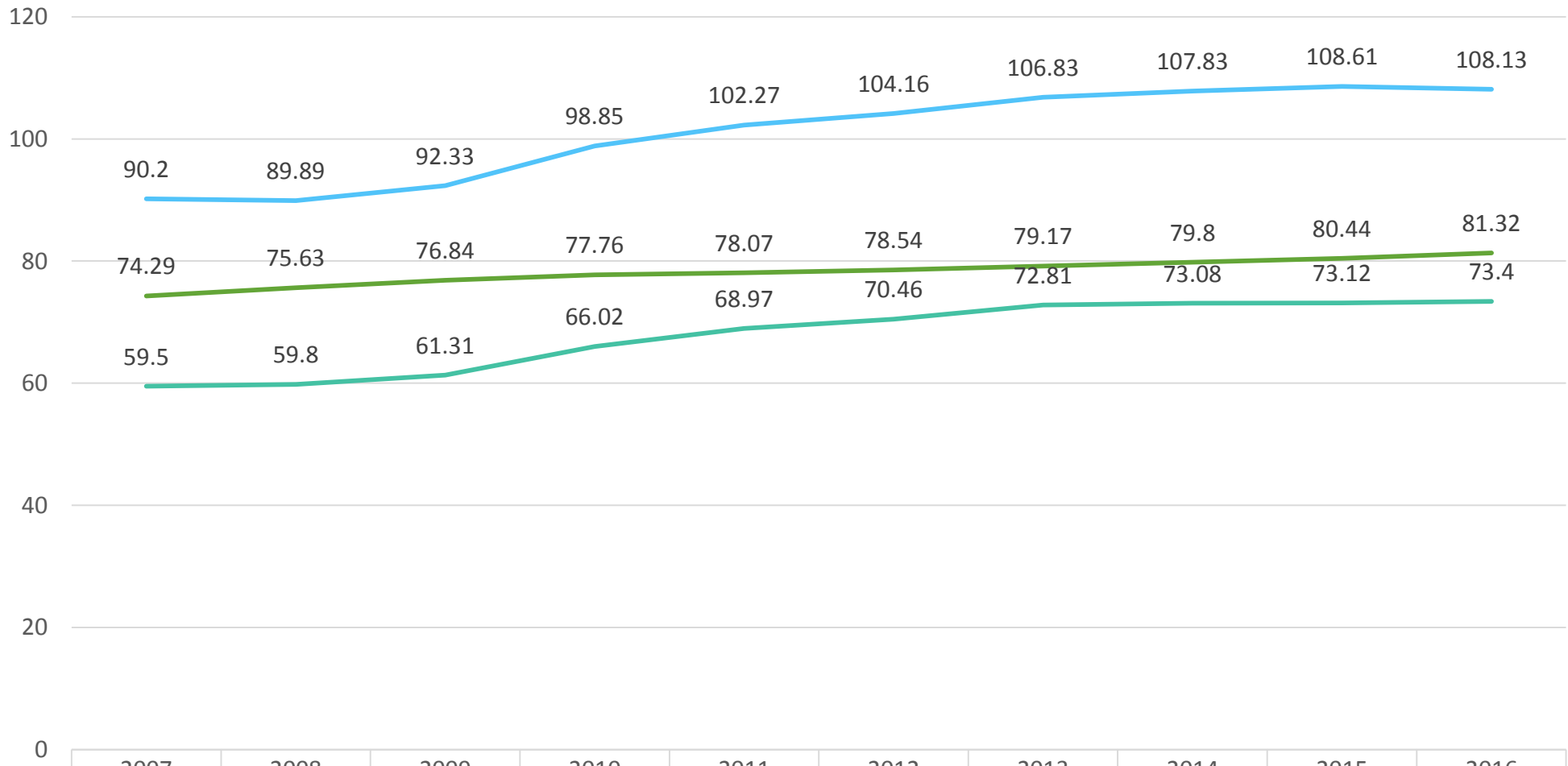
National legislative Issues

- Raising the RHC cap
  - Site neutral payment policies
- Hospice legislation
- Telehealth legislation

Raising the RHC cap

- NARHC continues to promote raising the RHC cap to at least $90.00 per visit for those RHCs subject to the cap.
- 2016 cap = $81.32

Reimbursement Comparison RHC Cap v 99213 v 99214



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
RHC Cap	74.29	75.63	76.84	77.76	78.07	78.54	79.17	79.8	80.44	81.32
99213	59.5	59.8	61.31	66.02	68.97	70.46	72.81	73.08	73.12	73.4
99214	90.2	89.89	92.33	98.85	102.27	104.16	106.83	107.83	108.61	108.13

RHC and FQHC Payment Limits Per Visit Over the Past 10 Years

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Rural Health Clinics	$74.29	75.63	76.84	77.76	78.07	78.54	79.17	79.8	80.44	81.32
Federally Qualified Health Centers (Rural)	99.17	100.96	102.58	108.81	109.24	109.9	110.78	111.76	112.56	
Federally Qualified Health Centers (Urban)	115.33	117.41	119.29	125.72	126.22	126.98	128	129.02	130.05	
Federally Qualified Health Centers Aggregate*										160.6

Provider-Based and Independent RHCs

Provider-Based Total Allowable Cost per Adjusted Encounter (2014)	**$172.09**
Independent Total Allowable Cost per Adjusted Encounter (2014)	**$112.59**

How do RHC costs compare to RHC payments?

RHC Type	Actual Payment	RHC Actual Costs
Independent	$81.32	$106.22
provider-based to CAH	$164.36	$164.36
provider-based to Hospitals <50 Beds	$152.75	$152.75
provider-based to Hospitals >50 Beds	$81.32	$148.97

Site Neutral Payments

- What is Site Neutral Payment Policy?
- Does this affect RHCs?

Site Neutral Payments

- This is essentially a policy whereby Medicare pays the same for a service regardless of the site in which it is performed.

- As of Bipartisan Budget Act of 2015 (The budget that Speaker Boehner resigned over), Medicare will no longer pay a higher fee to off-campus facilities designated as hospital outpatient departments for services that would have been covered under the physician fee schedule or ambulatory surgery schedule. Payment will be the same whether provided in the off-campus department or the physician's office.

EXHIBIT 2

Differences in Medicare Program Payments and Beneficiary Cost Sharing for Midlevel Outpatient Office Visits Provided in Freestanding Practices and Hospital-Based Entities, 2014

	Service provided in freestanding physician practice	Service provided in a hospital outpatient department		
	MPFS physician office rate[a]	MPFS physician facility rate[a]	OPPS rate[b]	Total hospital-based rate
Program payment	$58.46	$41.26	$74.02	$115.28
Beneficiary cost sharing	$14.62	$10.32	$18.51	$28.83
Total payment	**$73.08**	**$51.58**	**$92.53**	**$144.11**

SOURCE Medicare Payment Advisory Commission table updated by the author with 2014 payment rates from Centers for Medicare and Medicaid Services website. The *Current Procedural Terminology* code used for this example under the physician fee schedule is 99213. The Healthcare Common Procedure Code Set code used for this example under the outpatient prospective payment system (OPPS) is G0462. **NOTE** MPFS is Medicare physician fee schedule. [a]Paid under the Medicare physician fee schedule. [b]Paid under the OPPS.

Sound familiar?

- Although Provider-Based RHCs are **NOT** affected by this policy, it is something we should be prepared to deal with should it arise.
- To be clear there is no evidence that extending site neutral payment policies to RHCs is under active consideration

- What do we do if it does?

RHC cost per visit comparison (national data - 2014)

RHC Type	Actual Payment	With parent Overhead	Without Parent Overhead
Independent	$81.32	$106.22	$106.22
provider-based to CAH	$164.36	$164.36	$106.24
provider-based to Hospitals <50 Beds	$152.75	$152.75	$98.69
provider-based to Hospitals >50 Beds	$81.32	$148.97	$93.55

Parent provider overhead

- It appears that parent provider overhead is the sole factor explaining the cost difference between provider-based RHCs and independent RHCs.
- Provider-based RHCs are not more costly or less efficient than their independent colleagues.

Craig Thomas Rural Hospital and Provider Equity Act of 2016

- Introduced by Senators Al Franken (D-MN), John Barrasso (R-WY), Heidi Heitkamp (D-ND) and Pat Roberts (R-KS).
- Named after former Sen. Craig Thomas of Wyoming
- Essentially a wish list of items for Rural Health
- Raising the independent cap to $110 per visit
- Fixing the Hospice issue

RHC Relocation Issue

- NARHC is working to allow existing RHCs to change addresses within their own service area, even if that area is no longer rural or in a HPSA/MUA
- We are working with Members of Congress to send a letter to CMS asking them to reassess the current policy

Questions?

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